DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 0 8

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 7 million
b. FFY 2004 $ 7 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-A Pages ~~3, 6, 17-20~~ PAGES 1-28

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4-19-A Pages ~~3, 6, 17-20~~ 1-27

10. SUBJECT OF AMENDMENT:
Disproportionate Share Hospital

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

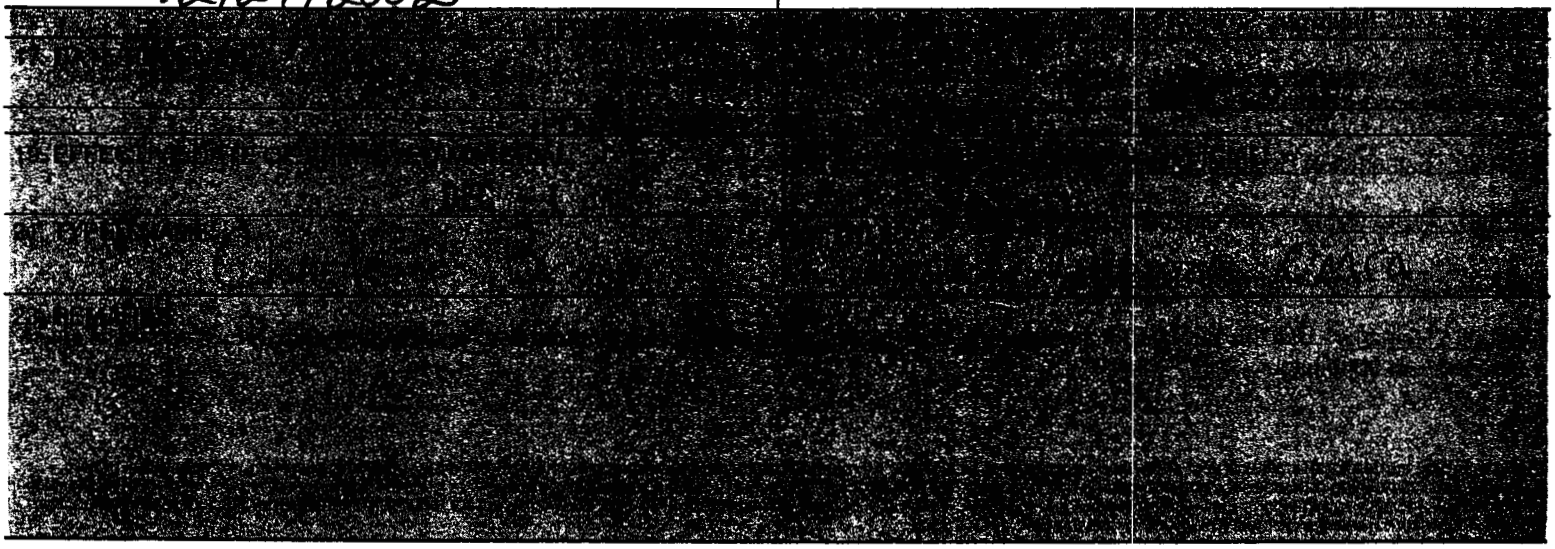
12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert J. Seiffert

13. TYPED NAME:
Robert J. Seiffert

14. TITLE:
Medicaid Adminstrator

15. DATE SUBMITTED:
12/24/2002

16. RETURN TO:
HHS - F&S
Attn. Margaret Froeschle
301 Centennial Mall South
Medicaid Division
Lincoln, Nebraska 68509



FORM HCFA-179 (07-92)

Instructions on Back

10-010 Payment for Hospital Services

10-010.01 (Reserved)

10-010.02 (Reserved)

10-010.03 Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services for the Nebraska Medical assistance Program excluding Nebraska Medicaid Managed Care Program's (NMMCP) capitated plans. This methodology complies with the Code of Federal Regulations and the Social Security Act through a plan which:

1. specifies comprehensively the methods and standards used to set payment rates (42 CFR 430.10 and 42 CFR 447.252);
2. provides payment rates which do not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles (42 CFR 447.272); and
3. takes into account the situation of hospitals which serve a disproportionate share of low-income patients (Social Security Act 1902(a)(13)(A)(iv).

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

This subsection applies to hospital inpatient discharges occurring on or after July 1, 2001.

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective rate established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

For rates effective July 1, 2001, and later, each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and disproportionate share adjustment(s).

10-010.03A Definitions: The following definitions apply to payment for hospital inpatient services.

Allowable Costs: Those costs as provided in the Medicare statutes and regulations for routine service costs, inpatient ancillary costs, capital-related costs, medical education costs, and malpractice insurance cost.

Base Year: The period covered by the most recent final-settled Medicare cost report, which will be used for purposes of calculating prospective rates.

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

Case-Mix Index: An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

Cost Outlier: Cases which have an extraordinarily high cost as established in 471 NAC 10-010.03B5 so as to be eligible for additional payments above and beyond the initial DRG payment.

Critical Access Hospital: A hospital certified for participation by Medicare as a Critical Access Hospital.

Diagnosis-Related Group (DRG): A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

Direct Medical Education Cost Payment: An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year, and are inflated to the midpoint of the rate year using the MBI.

Disproportionate Share Hospital (DSH): A hospital located in Nebraska is deemed to be a disproportionate share hospital by having -

1. A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or
2. A low-income utilization rate of 25 percent or more.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

DRG Weight: A number that reflects relative resource consumption as measured by the relative charges by hospitals for discharges associated with each DRG. That is, the Nebraska-specific DRG weight reflects the relative charge for treating discharges in all DRGs in Nebraska hospitals.

Hospital Mergers: Hospitals that have combined into a single corporate entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

Hospital-Specific Base Year Operating Cost: Hospital specific operating allowable cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, but exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Indirect Medical Education Cost Payment: Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education payments.

Low-Income Utilization Rate: For the cost reporting period ending in the calendar year preceding the Medicaid rate period, the sum (expressed as a percentage) of the fractions, calculated from acceptable data submitted by the hospital as follows:

1. Total Medicaid inpatient revenues including fee-for-service, managed care, and primary care case management payments (excluding payments for disproportionate share hospitals) paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services including fee-for-service, managed care, and primary care case management payments (including the amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals) in the same cost reporting period; and

2. The total amount of the hospital's charges for hospital inpatient services attributable to uncompensated care in ending in the calendar year preceding the Medicaid rate period, less the amount of any cash subsidies identified in item 1 of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to uncompensated care does not include contractual allowances and discounts (other than for uncompensated care for patients not eligible for Medicaid), that is, reductions in charges given to other third-party payors, such as HMO's, Medicare, or Blue Cross.

Market Basket Index (MBI): The estimate of the quarterly rate of change in the costs of goods and services that are representative of goods and services used by hospitals in the production of inpatient care, from HCFA's Prospective Payment System Input Price Index, using the most recent historical and forecast amounts.

Medicaid Allowable Inpatient Days: The total number of covered Medicaid inpatient days.

Medicaid Inpatient Utilization Rate: The ratio of (1) allowable Medicaid inpatient days, as determined by NMAP, to (2) total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Medicaid inpatient days include fee-for-service days, Medicaid managed care days, and days for primary care case management enrollees. Inpatient days for out–of-state Medicaid patients for the same time period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Medicaid rate period.

Medicaid Rate Period: The period of July 1 through the following June 30.

Medical Review: Review of Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay, completeness, adequacy, and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

Medicare Cost Report: The report filed by each facility with its Medicare intermediary.

The Medicare cost report is available through the National Technical Information Service at the following address:

U.S. Department of Commerce
Technology Administration
National Technical Information Service
Springfield, VA 22161

A hospital that does not participate in the Medicare program shall complete the Medicare Cost Report in compliance with Medicare principles and supporting rules, regulations, and statutes (i.e., the provider shall complete the Medicare cost report as though it was participating in Medicare).

The hospital shall file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees (see 471 NAC 10-010.03S). Note: If a nursing facility (NF) is affiliated with the hospital, the NF cost report must be filed according to 471 NAC 12-011 ff. Note specifically that time guidelines for filing NF cost reports differ from those for hospitals.

New Operational Facility: A facility providing inpatient hospital care which meets one of the following criteria:

1. A licensed newly constructed facility, which either totally replaces an existing facility or which is built at a site where hospital inpatient services have not previously been provided;
2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.
   Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

Operating Cost Payment Amount: The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Peer Group: A grouping of hospitals or distinct part units with similar characteristics for the purpose of determining payment amounts. Hospitals are classified into one of six peer groups:

1. Metro Acute Care Hospitals: Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The peer group base payment amount is the same for all hospitals in a peer group except Peer Group 6.

Rebasing: The redetermination of the peer group base payment amount or other applicable components of the payment rates from more recent Medicaid cost report data.

Recalibration: The adjustment of all DRG weights to reflect changes in relative resource consumption.

Reporting Period: Same reporting period as that used for its Medicare cost report.

Subspecialty Care Unit: Provision of comprehensive maternal and neonatal care services for both admitted and transferred mothers and neonates of all risk categories, including basic and specialty care services; provision of research and educational support; analysis and evaluation of regional data, including those on complications; and initial evaluation of new high-risk technologies.

Tax-Related Costs: Any real or personal property tax, sales tax, excise tax, tax enacted pursuant to the Medicaid Voluntary Contribution Provider Specific Tax Amendment of 1991 (P.L. 102-234) or any amendments thereto, franchise fee, license fee, or hospital specific tax, fee or assessment imposed by the local, state or federal government, but not including income taxes.

Uncompensated Care: Uncompensated care includes the difference between costs incurred and payments received in providing services to Medicaid patients and uninsured.

10-010.03B Payment for Peer Groups 1, 2, and 3 (Metro Acute, Other Urban Acute, and Rural Acute): Payments for acute care services are made on a prospective per discharge basis, except hospitals certified as a Critical Access Hospital. The total per discharge payment is the sum of -

1. The Operating Cost Payment amount;
2. The Capital-Related Cost Payment; and
3. When applicable -
   a. Direct Medical Education Cost Payment;
   b. Indirect Medical Education Cost Payment; and
   c. A Cost Outlier Payment.

10-010.03B1 Determination of Operating Cost Payment Amount: The hospital DRG operating cost payment amount is calculated for each discharge by multiplying the peer group base payment amount by the Nebraska-specific DRG relative weight. Health Care Financing Administration (HCFA) DRG definitions are adopted except for neonates.

10-010.03B1a Nebraska-Specific Weights: Two sets of weights are developed for DRGs for treatment of neonates. One set of weights is developed from charges associated with treating neonates in a subspecialty care unit for some portion of their hospitalization in hospitals meeting the criteria for providing subspecialty care. The second set of weights is developed from charges associated with treating neonates in hospitals that do not meet subspecialty care criteria. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

Hospitals must notify NMAP in writing within ten working days if their subspecialty care unit no longer meets the criteria for subspecialty care. Notification shall be sent to Department of Health and Human Services Finance and Support.

10-010.03B2 Calculation of Nebraska-Specific DRG Relative Weights and Case-Mix Index: Effective for the rate period beginning July 1, 2001, relative weights calculated for the rate period ending June 30, 2001, shall remain in effect until the next rebasing for Medicaid rate year beginning July 1, 2004. For the Medicaid rate period beginning July 1, 2004, for payment purposes, relative weights are calculated using all applicable discharges for a single year for a period from January 1, through December 31, for the calendar year ending 2 years prior to the effective date of the recalibration. Statistical outliers which exceeded the average mean charges value by three standard deviations are excluded from the calculations.

Nebraska-specific weights are calculated from Medicaid charge data using the following calculations:

1. Determine the Medicaid charges for each discharge;
2. Remove all psychiatric, rehabilitation; Medicaid Capitated Plans, and Critical Access Hospital discharges;
3. Determine the arithmetic mean Medicaid charges per discharge for each DRG by dividing the sum of all Medicaid charges for each DRG by the number of discharges;
4. Determine the statewide arithmetic mean Medicaid charges per discharge by dividing the sum of all charges for all relevant discharges in the State by the number of discharges;
5. For DRGs with 10 or more cases, divide the DRG arithmetic mean charges per discharge for each DRG by the statewide arithmetic mean charges per discharge to determine the Nebraska-specific relative weight for each DRG;
6. For DRGs with less than 10 cases, relative weights will be borrowed from the Medicare relative weights that were effective for the Medicare program on October 1 of the preceding year.
7. Adjust the relative weights so that the average of all discharges equals 1.0.

10-010.03B2a Recalibrating Relative Weights: Effective the rate period beginning July 1, 2004, DRG relative weights will be recalibrated every three years during each rebasing of prospective rates.

10-010.03B2b Calculating the Base Year Case Mix Index: For purposes of determining base rates, a base year case mix index is calculated for each hospital using all applicable claims with a first date of service that is within the base year cost reporting period. Facility specific base year case mix indices are calculated as the sum of relative weights for all base year claims, divided by the number of claims.

10-010.03B3 Calculation of Case-Mix Adjusted Hospital-Specific Base Year Operating Cost Per Discharge: Medicaid case-mix adjusted hospital-specific base year operating costs per discharge amounts are calculated from base year Medicare cost reports. For purposes of this calculation, the Medicare cost report which the Department shall use in the computation of the prospective rate process for any hospital which files more than one Medicare cost report for reporting periods ending during any calendar year is the one which covers -

1. At least nine months, and
2. The greatest period of time.

For any hospital which files Medicare cost reports for more than one reporting period ending during a calendar year but does not file a cost report covering a period of at least nine months, the computation rates will be based on aggregate data from all cost reports filed for reporting periods ending during that calendar year.

The Department may utilize cost report data that is not final-settled in instances where a final-settled Medicare cost report for a hospital is not available. For example, if two hospitals merge into a single provider entity, and the combined provider entity does not have a combined cost report that is final-settled, the Department may utilize a more recently completed combined cost report that is not final-settled.

Operating costs are calculated as follows:

1. Routine service costs - Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing-bed costs and observation bed costs.
2. Inpatient ancillary service costs - Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers.
3. Total hospital-specific base year operating costs amounts are equal to the sum of Medicaid routine service costs and Medicaid inpatient ancillary service costs, less the building and fixtures portion of capital-related costs and direct medical education costs.